

ELECTRONIC BENEFITS TRANSFER - EBT

Client Claim

DATE

CLIENT NAME

CASE NUMBER

Date : _____ Time: _____ Amount: \$ _____

Location: _____

Please include EBT receipt or other proof.

☐ Cash Aid ☐ Food Stamps☐ Wrong amount credit☐ Wrong amount debit☐ No transaction made on date indicated☐ Other (*Explain*): _____

Tell us the facts: _____

I know the facts I give will be checked out by the county. I will be notified of the county decision. Any amount owed to me will be put into my EBT account. Any amount I owe will come out of my balance, and if not enough, my next month's benefit will be used.

CLIENT SIGNATURE

DATE